

## FISCAL YEAR 2006 ANNUAL PERSONAL CARE HOME SURVEY

### - IMPORTANT NOTICE ABOUT SURVEY ACCURACY AND COMPLIANCE -

The information and data collected through this survey are used for state regulatory and planning purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. This survey is required under Department of Community Health Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.05, and other regulations or statutes.

The chief executive officer, executive director or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important. See Rule 111-2-2-.04(e) prohibiting survey revisions unless approved by the Department at its sole discretion.

Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1)(b), 111-2-2-.05(1)(a)1, and 111-2-2-.05(1)(a)7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

## INSTRUCTIONS AND DEFINITIONS

### *REVIEW INSTRUCTIONS AND DEFINITIONS BEFORE COMPLETING THE SURVEY*

The Annual Personal Care Home Survey is being administered for all personal care homes with 25 or more beds operated in Georgia. The survey instrument will not allow submission of an incomplete survey form. Please ensure your facility retains a copy of the Access file or at least one copy of the completed survey for your records.

Please respond to all questions. When a numerical answer is required, enter "0" (zero) if that is the correct response.

Unless otherwise noted, data should be submitted for the entire Report Period or the last day of the Report Period as requested. If the personal care home was sold or leased during the Report Period, it is the responsibility of the **current personal care home operator** to obtain all necessary records from the previous operator(s) to complete this survey.

Some totals must balance and agree with relevant totals in the survey. If relevant totals do not balance and agree as appropriate, the survey instrument will prompt the respondent and will not allow submission of the survey.

If you have any questions, please contact: Virginia Seery with the Division of Health Planning at 404-656-0463 or by e-mail at [vseery@dch.ga.us](mailto:vseery@dch.ga.us)

## **PART A: GENERAL INFORMATION**

1. **Respond as requested.**
2. **Report Period:** July 1, 2005 through June 30, 2006 is the **required** report period. If the facility was in operation for a full year **you must** report data for a full year. If the ownership, operation or management of the facility changed during the report period, it is the responsibility of the **current owner or operating entity** to obtain the necessary data from the prior owner or operator.

## **PART B: CONTACT INFORMATION**

Provide the name, title, email address, fax, and phone numbers of the person authorized to respond to inquiries about responses to the survey. This person must retain a copy of the completed survey.

## **PART C: OWNERSHIP, PROGRAMS & LICENSURE**

Enter the full legal names of the entities that owned, operated, and managed your facility as of the **last day of the Report Period**. Use the organization types from the drop-down list to describe each owner/management category. **If a category is not applicable, leave blank.**

### **DEFINITIONS:**

**Facility Owner** - refers to the person or entity that owns the building and grounds. Include the appropriate organizational code from the table in question C.1. and the effective date by month, day and year.

**Facility Operator** - refers to the owner of the business accountable for the profits and losses. Include the appropriate organizational code from the table in question C.1 and the effective date by month, day and year.

**Management** - refers to a specific entity with whom the Owner or Operator has contracted to manage the routine business. Include the appropriate organizational code from the table in question C.1 and the effective date by month, day and year.

**Lessee** - refers to the entity that has rented the actual building in which the business is operated.

**Sub-lessee** - refers to the entity that has rented from the original lessee.

**Changes** - refers to any Owner or Operator changes that occurred during the report period **7/1/05 through 6/30/06** or after the last day of the Report Period. This should **NOT** reflect any change solely in administrators.

**Other Health Care Facilities** - refers to health care organizations such as but not limited to nursing homes, hospitals, home health agencies, ambulatory surgery centers, personal care homes, and hospices.

**Organizational Affiliations** - refers to your facility being affiliated with a retirement complex, a licensed personal care home, a hospital, or a hospice. Generally, such affiliations are indicated when the facilities are on the same campus and share the same administrative control.

### **Special Programs:**

**Alzheimer's Disease Program:** – planned and structured array of services and daily routines for persons with Alzheimer's Disease/Dementia.

**Respite Care Program:** – an organized program that provides care and supervision to a dependent client to sustain the family or other primary care giver by providing that person with temporary relief from the ongoing responsibility of care.

**Mental Retardation/Mental Health Residential:** – an organized program serving the mentally retarded or mentally ill in a residential setting. Such programs may include services provided under programs such as the Medicaid Mental Retardation Waiver.

**Adult Day Care Program:** – a program that provides adults with personal care in a protective setting outside their own homes during a portion of a 24-hour day.

## **PART D: BEDS AND UTILIZATION**

### **DEFINITIONS:**

#### **Admissions and Discharges**

**Beds Set Up and Staffed** - all beds that are staffed with personnel including both occupied and unoccupied beds. Temporary changes in the number of beds due to renovations, painting, etc., do not affect bed count as reported here.

**Percent of Private Insurance Residents** – The average percent of total residents served during the report period that paid by private insurance (long term care insurance) in whole or in part.

**Average Daily Bed Occupancy** – The average number of beds rented per day out of all the days during the report period.

**Average Monthly Room and Board Charge** – The average of the monthly room and board charges for the report period. Include only room and board charges. Do not include extra services such as transportation, laundry, etc.

**Admission** - the formal acceptance of a resident who is to receive inpatient services in the facility.

**Discharge** - the release of a resident from the facility, who was discharged to home, transferred to another institution, or died.

#### **Race/Ethnicity Categories: (as defined by the U.S. Census Bureau)**

**American Indian or Alaska Native** - A person having racial origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

**Asian** - A person having racial origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, but not limited to, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**Black or African American** – A person having racial origins in any of the Black racial groups of Africa.

**Hispanic or Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish Origin” can be used in addition to “Hispanic” or “Latino.”

**Native Hawaiian or Other Pacific Islander** – A person having racial origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**White** – A person having racial origins in any of the original peoples of Europe, the Middle East, or North Africa. Include people who indicate their race as “White” or report entries such as Irish, German, Lebanese, Near Easterner, Arab, or Polish.

**Multi-Racial** – A person having racial origins from two or more of the above definitions.

## **Part E: Financial Data and Indigent/Charity Care**

Under the certificate of need (CON) planning guidelines, many personal care homes are required to provide some level of services to persons who are eligible for indigent and charity care. The CON process requires that the state collect data on certain, limited financial information to monitor indigent and charity care services as well as overall financing trends in the personal care home industry. Part E is designed to collect the information necessary to meet those requirements.

Please limit responses regarding financial information to services related to the personal care home only. Do not include other types of services or programs that may be administered by the facility. Please use the following definitions when answering questions in this section:

**Gross Revenue** – Gross Revenue should reflect total billings for all personal care home residential services during the year. Number of residents should reflect the total number of residents billed during the year.

**Bad Debt** – Bad Debt should reflect any portion of the billings that residents legally owed but failed to pay. Number of residents should reflect the total number of residents with unpaid bills during the report year.

**Indigent and Charity Care** – Indigent and Charity Care should reflect service costs that were written off or forgiven by the home because the resident qualified for indigent or charity care pursuant to state law or the home's charity policy which authorizes certain residents to receive free services or services at a reduced cost. **A resident whose income is at or below 125% of the federal poverty level (FPL) must be in the indigent category unless they have a payer (Medicare or Medicaid). Charity cases must have an income that is above 125% FPL.** Number of residents should reflect the total number of residents who qualified as indigent or charity care cases during the year.

## **PART F: PATIENT ORIGIN:**

**Patient Origin** – This represents the Georgia county or other state where each resident was living most recently on a permanent basis prior to becoming a resident of your facility. This must reflect either a Georgia county or, if the patient was from out-of-state, the state from which the resident moved.

## **PART G: ELECTRONIC SIGNATURE**

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer, Executive Director or Principal Administrator of the facility pursuant to Rule 111-2-2-.04(1)(6). The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.